



Name: \_\_\_\_\_ Gender: \_\_\_ Age: \_\_\_ Date: \_\_\_\_\_

(No need to complete the following 2 lines if you are also submitting a Breast Health History Form with this exam)

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Referred by: \_\_\_\_\_

Are you currently experiencing any pain, symptoms or concerns?  None

Please describe:

Abdomen \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Back \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Neck \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Face \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Nasal/Sinus \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Teeth/Mouth \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Digestion/Elimination \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Respiratory \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Urinary \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Male / Female Organs \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other organs (kidneys, liver, gall bladder, pancreas, spleen, thyroid) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Do you have a history of:**

- Stroke       Cardiovascular Disease       Dizziness       Fainting

Please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Past injuries to the abdomen, back, face, or neck requiring evaluation/treatment by a healthcare provider       None

Please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Past surgeries to the abdomen, back, neck, face or teeth/gums (Please provide year of surgery)       None

Please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Diagnosed diseases or conditions       None

Please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Please list your current prescription medications (not supplements):**       None

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Client or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_